MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 08105 0

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 Mo.
Hospital, institution, or street address where death occurred:
PINEL CLINIC
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: MARYLAND County:
City or town: BALTO.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 3604 SEGUOIA AVE
(If rural, give LOCATION)
2.(a) If veteran, name war:

3.(a) FULL NAME: SOPHIE BLEIBERG

3.(b) Social Security Number:

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Widow

6.(b) Name of husband or wife: (W. BENJ.

6.(c) If alive, give age: years

7. Birth date of deceased (mo., day, yr.)

8. AGE: Years: 65 | Months | Days | If less than one day: hrs. min.

9. Birthplace: RUSSIA
(Town, county, and state)

10. Usual occupation: HOUSEWIFE

11. Industry or business

FATHER
12. Name: BOROCH –
13. Birthplace: RUSSIA

MOTHER
14. Maiden name: BESSIE –
15. Birthplace: RUSSIA

16. Informant: JACOB J. EDELMAN
Address: 1614 WYNNS FALLS PKWAY

17. BURIAL (Burial, cremation, or removal. Which?) Date thereof: 8-15-45 (month) (day) (year)
Cemetery or crematory: UNITED HEBREW CEM.
Location: WASHINGTON BLVD.

18. Funeral director: JACK LEWIS, INC
Address: 1439 E. BALTO. ST

19. 8/15/45 (Date rec'd by registrar) City Health Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 13 1945, at 7P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 10 1945 to Aug. 13 1945
and that I last saw her alive on Aug 13 1945

	DURATION
Immediate cause of death: Chronic Glomerulo Nephritis	?
Due to:	
Due to:	
Other conditions:	

(Include pregnancy within 3 months of death)

Major findings of operations:
Date of op.:
Autopsy results:
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of:
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?):
Means of injury: Injured at work?

23. SIGNATURE: Jean A. Kershman, MD M. D. or other
Address: Ellicott City Md Date signed: 8/13/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 18

CERTIFICATE OF DEATH

18196

★ Reg. Dist. No. 195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County: Howard
City or town: Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 27 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Md. County: Howard
City or town: Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME: Bertha Condon

3.(b) Social Security Number

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
F	W	married

6.(b) Name of husband or wife: Emery Condon
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Jan 25 - 1890

8. AGE: Years 55 | Months 9 | Days 2 | If less than one day: hrs. min.

9. Birthplace: Va.
(Town, county, and state)

10. Usual occupation: Housewife

11. Industry or business:

FATHER
12. Name: Thomas J Hitt
13. Birthplace: Va.

MOTHER
14. Maiden name: Mary F. Jenkins
15. Birthplace: Va.

16. Informant: Emery Condon
Address: Savage Md

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug 28-45 (month) (day) (year)
Cemetery or crematory: Savage
Location: Savage Md

18. Funeral director: Leslie Lauer
Address: Laurel Md

19. 8/27/45 (Date rec'd by registrar) Registrar: Frank Shipley

MEDICAL CERTIFICATION

20. DATE OF DEATH: August 25th 19 45 at 6 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 12 19 45 to Aug. 25 19 45 and that I last saw her alive on Aug. 25 19 45

Immediate cause of death	DURATION
Coronary Thrombosis	12 hrs.
Due to: Hypertensive - cardio - Vascular disease	?
Due to: arteriosclerosis	?
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations: ✓

Date of op.

Autopsy results: ✓

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE: Frank Shipley, M. D.
M. D. or other
Address: Savage, Md. Date signed 8/27/45

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (50)

CERTIFICATE OF DEATH

08117

Reg. Dist. No. 191

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

VS A1b

1. PLACE OF DEATH:
County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State: Maryland County: Howard
City or town: Ellicott City
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war: None

3. (a) FULL NAME: Eva May Cross

3. (b) Social Security Number: None

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
Female	White	Married

6.(b) Name of husband or wife: Harry Lee Cross
6.(c) If alive, give age: 61 years

7. Birth date of deceased (mo., day, yr.): Aug. 3, 1888

8. AGE: Years	Months	Days	If less than one day
57	—	15	hrs. min.

9. Birthplace: West Friendship, Md. (Town, county, and state)
10. Usual occupation: Housewife
11. Industry or business: Own Home

FATHER
12. Name: George M. Ridgely
13. Birthplace: West Friendship, Md.

MOTHER
14. Maiden name: Matilda Gaither
15. Birthplace: Sykesville, Md.

16. Informant: Harry Lee Cross
Address: Ellicott City, Md.

17. Burial (Burial, cremation, or removal. Which?) Date thereof: Aug. 21, 1945 (month) (day) (year)
Cemetery or crematory: Mount View
Location: Slacks Corner, Md.

18. Funeral director: Easton Sons
Address: Ellicott City, Md.

19. Aug 20, 1945 (Date rec'd by registrar) John B. Leughman, Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH: Aug. 18, 1945, at 10:32 A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 18, 1944 to Aug 18, 1945 and that I last saw h[illegible] alive on Aug 18, 1945

Immediate cause of death	DURATION
Carcinoma of breast with metastasis	1 yr.
Due to	
Due to	
Other conditions	

(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide: Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury: Injured at work?

23. SIGNATURE: Jem A. Kochman, M.D. M. D. or other
Address: Ellicott City Md Date signed: 8/18/45

08108

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 92

CERTIFICATE OF DEATH

★ Reg. Dist. No. 195

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARGIN RESERVED FOR BINDING

VS A15

1. PLACE OF DEATH:
County Howard
City or town Savage
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 yrs.
Hospital, Institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Md. County Howard
City or town Savage
(If outside city or town limits, write RURAL and give nearest town)
Street No.
(If rural, give LOCATION)
2.(a) If veteran, name war

3.(a) FULL NAME Charles Edward Sterbt

3.(b) Social Security Number 219-01-7914-A

4. Sex	5. Color or race	6.(a) Single, married, widowed, or divorced
M.	W.	Married

6.(b) Name of husband or wife Maude J. Sterbt
6.(c) If alive, give age ..... years

7. Birth date of deceased (mo., day, yr.) Feb. 17 1874

8. AGE: Years	Months	Days	If less than one day
71	5	26	..... hrs. ..... min.

9. Birthplace Md. (Town, county, and state)
10. Usual occupation Clerk
11. Industry or business Store
FATHER 12. Name Jacob Sterbt
FATHER 13. Birthplace Frederick Co. Md.
MOTHER 14. Maiden name Mary Jones
MOTHER 15. Birthplace Frederick Co. Md.
16. Informant Maude J. Sterbt
Address Savage, Md.
17. Buried (Burial, cremation, or removal. Which?) Date thereof Aug 14, 1945 (month) (day) (year)
Cemetery or crematory Savage Md.
Location Savage Md.
18. Funeral director H. Stuart Donaldson
Address Laurel Md.
19. 8/13/45. (Date rec'd by registrar) Frank Shipley Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH August 11th 1945 at 9 P. M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 1st 1945 to Aug. 11th 1945
and that I last saw him alive on Aug. 11th 1945
Immediate cause of death Myocardial Insuff. — DURATION: Months
Due to Arteriosclerosis — 4 yrs.
Due to
Other conditions
(Include pregnancy within 3 months of death)
Major findings of operations ✓ Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide ..... Date of .....
Where did injury occur? ..... (City or town) (County) (State)
Injured at home, farm, industry, public place (where?) .....
Means of injury Injured at work?

23. SIGNATURE Frank Shipley, M.D.
M. D. or other
Address Savage Md. Date signed 8/13/45

1945
1872
73

20.
45
73

1945
24
1872
13